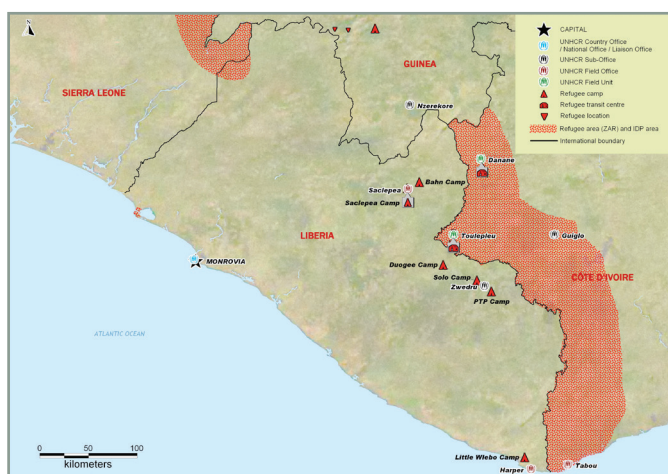


Continuation of Antiretroviral therapy for Ivorian refugees in Liberia during the emergency phase (2011-2012)

CONTEXT

The 2010 political turmoil and subsequent violence in Côte d'Ivoire due to the disputed presidential election outcome resulted in the displacement of more than 224,000 Ivorian refugees into Liberia. During the initial period

of the crisis, the majority of the refugees (65%) were hosted in more than 300 host communities while the remaining refugees were hosted in six refugee camps.



The 2007 population-based Liberian Demographic and Health Survey (LDHS) showed a low-level, generalized HIV epidemic with an HIV prevalence rate of 1.5% among the general population aged 15-49 years. According to a 2009 UNAIDS/WHO estimate, Côte d'Ivoire has a generalized HIV epidemic with the highest overall prevalence rate of 3.4% in the West African region. However the data

describes a generalized epidemic marked by striking gender and geographic differences (female 6.4% vs. male 2.9%; 1.7% in the Northwest to nearly 6% in the South and East and 6.1% in Abidjan). The number of people living with HIV (PLHIV) receiving ARV treatment in 2011 was 89,410 out of the 234,000 eligible persons (Rapport National GARP Côte d'Ivoire 2012).

Since the beginning of the influx of Ivorian Refugees into Liberia in late 2010, UNHCR and partners including CHES, MSF, IRC, EQUIP, MERLIN, Tiyatien Health (TH), Child Fund, and MERCI have worked actively in communities and the refugee camps to ensure access to health services including access to antiretroviral therapy (ART). This was done in collaboration with the Ministry of Health and Social Welfare (MoHSW) and the National AIDS Control Program (NACP) of the Republic of Liberia. Refugees came into Liberia with varied patient profiles; some knew their HIV status and had their antiretroviral medicines while others had experienced significant interruption in

treatment before accessing care. Through provision of services in early 2011, some refugees learned of their status after receiving HIV Testing and Counseling (HTC) while in Liberia.

ACTION FOR CHANGE

At the onset of the emergency, priority action was to identify those who were already on ART to ensure that they continue the treatments. Information on the absolute need of not interrupting ART and where to access services was delivered at different points;

- 1) In registration centres information was provided on services. To ensure maximum confidentiality only information on where to access services was provided.
- 2) At household by community health workers (CHWs) who were mobilized to conduct outreach and awareness in communities that were receiving refugees. They provided information on availability of HTC services and ART treatment centre.
- 3) Posters and broadcast of radio messages were done on availability and the sites of HIV/AIDS services, with particular focus on HTC and ART.

By the end of 2011, there were 132 refugees who were on ART of whom the 70 % were newly initiated in Liberia and 30 % were continuation.

INTERVENTION AND POSITIVE OUTCOMES

- Continued access. Information dissemination on availability of HTC and ART services, through various mechanisms including registration centres, community volunteers, the media, and in health facilities, supporting in transportation to the HTC and ART centers significantly helped to ensure continued access.
- HIV Testing. The roll out of treatment programmes, was used as an opportunity to further expand the HIV programme, and access to HIV testing services was provided early in the emergency in late 2010-first half of 2011. The importance of HTC and Prevention of Mother to Child Transmission of HIV/AIDS (PMTCT) was promoted among refugees and community members from as early as January 2011 and March 2011 respectively. People that tested HIV positive were referred to the nearest ART site for comprehensive HIV care and treatment by trained clinicians.
- Follow Up. Weekly follow up of all patients was done and implementing partners assisted in either transporting them or providing stipends for transportation to the ART centers for regular refill of medications. This immensely helped to ensure uninterrupted ART in a context where there were only few ART sites in the counties where refugees were hosted, and where patients were to travel long distances to access treatment.
- Integration of Prevention and Care and Treatment. Awareness and prevention programmes, including condom distribution, were conducted in both the refugee camps as well as the villages that hosted refugees. ART, PMTCT, and TB services were provided via referrals to the nearest district health facility providing these



UNHCR Liberia, Tiyatien Health Staff at ART
clinic in Grand Gedeh. 2011

services. Two critical elements of success were the use of the existing sustained presence on the ground where refugees were living and the individualized follow-up from facility to community by cadre of CHWs to ensure continuity of treatment.

- Monitoring and evaluation. Health partners conducted regular reviews of HIV and AIDS services in general and ART services in particular in order to improve the quality of the response, shared best practices, developed strategies to overcome constraints, and prepared for emerging health needs in border counties.

LESSONS LEARNED

- The support from the National AIDS programme in Liberia facilitated the implementation of key HIV activities at the onset of the influx of refugees in Liberia.
- By integrating refugees into national HIV programmes, refugees and the surrounding populations benefitted both from improved access to HTC and ART programmes.
- CHWs and socio-economic support such as a transport stipend and access to food support enhanced clinical effectiveness for those on ART. The CHWs are instrumental for rapid response, case detection, retention of patients, and psychosocial support, socio-economic support encourages PLHIV to take drug adherence.

- Building on existing partnerships between UNHCR partners, and County Health Teams under the MoHSW Pool Fund, served as an essential foundation for coordination and communication at the start of the emergency and eased the incorporation of new health actors as the response progressed.

CHALLENGES

- Follow Up. Some patients who tested positive for HIV were eventually lost to follow up after initial testing and/or initiating ART due to spontaneous repatriation and cross border movement, specifically in the early stages between February and June 2011. For those patients that returned to their homeland during this early stage, there was no mechanism available to know if they were able to access appropriate care and treatment, as we do not know where they returned to in Cote D'Ivoire.
- Access to ART and Supply Chain Management. There were only few ART sites in the counties where refugees were being hosted, and stock outs of medicines and supplies, including ARVs were experienced resulting in patients traveling for long distances.
- Human Resource Challenges. The majority of health care workers are concentrated in the capital where training also takes place and not rural areas. Rural clinics experience a high staff turnover.
- Laboratory capacity. While UNHCR has donated a CD4 machine to the main health centre in Nimba, lack of CD4 testing capability has been a big challenge in many facilities. For children on Neverapine in the PMTCT program, PCR testing is only available in a few facilities. Lack of chemistry machines in many care centres makes it difficult to monitor patients on ARVs for toxicity and other side effects. Diagnostic capacity to detect or rule out other diseases is also highly limited in most settings.

CONCLUSIONS

The National AIDS Programme, UNHCR and its partners were able to respond effectively in the provision of ART at the onset of an emergency. By December 2012, there were a total of 147 refugees on ART (20 in Nimba, 113 in Grand Gedeh, and 14 in Maryland). This was facilitated by strengthened partnerships between government and development partners and promoting the uptake of HTC/PMTCT services.

Scale up to support delivery to ensure the availability of medicines and supplies, strengthen socio-economic support for people living with HIV, and engage in campaigns to reduce stigma and discrimination are critical. Moreover, to address service gaps counties should explore motivational packages that are in line with MoHSW policy and promote staff retention. Finally, ART training should be decentralized to enable facilities to train more than one provider as well as ensure adequate and appropriate medical equipment and supplies.